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ABSTRACT

The author describes his "Target Approach" to counseling depressed and/or suicidal patients. By tailoring a technique to selected characteristics ("targets") of the depression as well as to the personality of the patient, more effective counseling is achieved. This target approach involves 3 steps: (1) breaking the problem of depression into specific, manageable units; (2) selecting the specific units to be worked on; and (3) determining what types of therapeutic intervention would be appropriate for this particular patient. Included is a list of common target symptoms with some suggestions for therapy. (Author/HMV)

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COGNITIVE MODIFICATION IN DEPRESSED, SUICIDAL PATIENTS

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RATIONALE

The riddle of depression has intrigued theoreticians, clinicians, and experimentalists. No other syndrome so crassly violates accepted canons of human nature: the survival "instinct," maternal "instinct" and the pleasure principle. Moreover, the basic syndrome appears to extinguish, or at least disrupt, basic biological drives such as hunger, sleep, and sexual desire. The author has indicated how these paradoxical phenomena of depression can be fitted into a coherent pattern and can present multiple points of entry for psychotherapeutic intervention (Beck, 1963, 1972).

The various characteristics of depression can be viewed as expressions of an underlying shift in the depressed patient's cognitive organization. Because of the dominance of certain cognitive schemas, he tends to regard himself, his experiences, and his future in a negative way. These negative concepts are apparent in the way the individual systematically misconstrues his experiences and in the content of his ruminations. Specifically, he regards himself as a "loser."

First, he believes that he has lost something of substantial value such as a personal relationship or that he has failed to achieve what he considers an important objective. Second, he expects the outcome of any specific activity that he undertakes to be negative and, therefore, he is not motivated to set goals and in fact will avoid engaging in "constructive" activities. Furthermore, he expects his entire future life to be deficient in satisfactions, achievements, etc. Third, he sees himself as a "loser" in the

vernacular sense: He is inferior, inept, lacking in worth, awkward, and socially undesirable.

The patient's negative concepts contribute to the other symptoms of depressions such as sadness, passivity, self-blame, loss of pleasure response, and suicidal wishes. As a result of a vicious cycle, the negative thinking, unpleasant affects, and self-defeating motivations reinforce each other. The general formula for counteracting depression is to use techniques that will enable the patient to see himself as "a winner" rather than a "loser"; as masterful rather than helpless.

DESCRIPTION OF TARGET APPROACH

At one time, I used almost all of the usual approaches described in the literature. Sometimes particular methods seemed to help and at other times to have an adverse effect; expressing abundant warmth and sympathy; "getting out his anger"; encouraging the patient to express his sad or guilty feelings; interpreting "his need to suffer." In general, my approach was rather global, and was not directed towards any of the specific phenomena of depression. However, talking about how miserable and hopeless they felt and trying to squeeze out anger often seemed to accentuate the patients' sad feelings; their tacit acceptance of their debased self-image and pessimism simply increased their sadness, passivity, and self-blame.

In the course of time, I found that tailoring a technique to selected characteristics ("targets") of the depression as well as to the personality of the patient was far more effective than the previous approach.

This target approach involves, first of all, separating the picture of depression into its specific components. Conceivably, the therapist could start with any one of the phenomena -- emotional, motivational, cognitive, behavioral or physiological -- and concentrate his efforts on changing that one phenomenon. Since each of the components of depression contribute to other components, it might be anticipated that an improvement in any one problem area would lead to an improvement in other areas, which would finally spread to include the entire syndrome of depression.

The specific targets and techniques to be selected depend on the therapist's judgment. He needs to sound out the patient and reach a consensus on which problem(s) to tackle first and what methods to use. Generally, in the more severely depressed patients a "behavioral" target such as passivity is selected and special activity programs are set up. (e.g. "Graded Task Assignment", "Success Therapy") Of course, several targets and methods may be focussed on concomitantly. A certain amount of trial-and-error and ingenuity is necessary. Moreover, it must be emphasized that the approaches must be tailored for the specific patient.

For instance, the therapist could select the individual's low self-esteem as the specific target. By the application of the appropriate technique (of a cognitive, behavioral, or relationship character) it is possible to improve the self-esteem. As the individual starts to think better of himself in terms of his ability to control his environment, to be effective in situations, he begins to expect that the outcome of his efforts might be to some avail. This then increases his optimism and expectancies. As has already been pointed out, an increase in expectancies improves

motivation. The increased motivation leads to better performance. As the patient correctly evaluates this improved performance, he is likely to experience an even bigger boost in self-esteem and at the same time, may begin to experience some gratification from (a) the sense of having accomplished something tangible and (b) from raising his level of esteem. One can see that a complete cycle has been completed through this particular maneuver. Any other element, however, in the cycle could potentially be used as a point of intervention.

As has been pointed out previously, a person's sense of receiving a meaningful addition to his personal domain stimulates pleasureable feeling. (Of course, because of the depressive's tendency to downgrade or discredit anything positive, he screens out many experiences that would ordinarily be construed as additions.) When the patient does this, it should become the focus for discussion and then application of a specialized technique (e.g. M & P Therapy).

In summary, then, the target approach consists of breaking the problem of depression into specific, manageable units, selecting the specific units to be worked on, and then determining what types of therapeutic intervention would be appropriate for this particular patient.

SYMPTOM, TECHNIQUE, AND MALADAPTIVE CONSTRUCT

In defining the approach to depression, it is important to distinguish among symptom, technique, and construct. For example, the symptom may be affective, such as crying spells, sadness, loss of gratification, loss of sense of humor, apathy. The therapeutic approach may be behavioral; for example, mobilizing the patient

into more activity and positively reinforcing certain types of activity; or using imagery techniques such as the visualization of pleasant scenes. The underlying attitude, however, is the component that needs to be changed if the totality of the depression is to be influenced. Thus, the goal is cognitive modification.

For example, engaging in activity (behavioral method) may help to neutralize the cognition, "The future is hopeless because I cannot do anything constructive." Similarly, visualizing pleasant scenes may help to neutralize or change the negative cognitive set that everything is unpleasant. Hopefully, it may also produce some gratification (affective) which can similarly modify the individual's cognitive set to: "It is possible for me to experience some satisfactions rather than just continuous unremitting pain."

Merely zeroing in on the symptom (e.g. sadness; wish to die; retarded behavior) without designing a program to affect attitude change simultaneously may produce only temporary change. In fact, this "improvement" may be deceiving in that a single outward characteristic of depression is apparently changed but the central core of the depression is not touched. For example, a patient who is persuaded to engage in more activity may appear "better" but may then kill himself. It is essential, therefore, that the therapist be alert to signs of improvement in other attributes of depression as well as in fundamental attitudinal change.

Even though this formulation emphasizes the cognitive set, it is important to focus on a variety of targets (and also to use whatever techniques seem to be appropriate for a given patient). There are two reasons for this.

First, as pointed out previously, there is a vicious cycle in depression. The overt behavior influences cognition which, in turn, influences affect. However, the direction of this cycle can be reversed. For example, as a result of therapy, a patient becomes more constructive. He observes his behavior and thinks, "I can do more things than I thought I could." This self-observation increases his motivation to expand his range of activities. As he achieves additional concrete goals, he experiences further improvement in his attitudes towards himself and towards the future. His improved self-image and increased optimism reduces his self-criticisms, pessimism, and sadness and he may, in fact, begin to experience some satisfactions.

Secondly, the importance of trying to amelioriate the patient's sadness and other affective disturbance as soon as possible is obvious. The depressed patient frequently reports that none of his usual sources of gratification bring him pleasure anymore. In Costello's terms, he experiences loss of "reinforcer effectiveness." Through some techniques, possibly of a verbal nature, it is possible to get the patient to feel sorry for himself, cry, or experience genuine amusement. This kind of affective experience may help to thaw out his frozen affect. "De-icing" the affect, is a crucial mechanism in the treatment of depression.

It is also possible in the mildly and moderately severe depression that the expression of anger also may serve to shake loose positive affect -- probably because it helps to change the individual's cognitive set. It seems far-fetched to assume that dysphoria is transformed into anger by some kind of alchemy. It is more likely that the individual begins to see himself as a more

effective human being when he expresses anger. The experience of anger is not only far more pleasant than sadness but has connotations of power, superiority, mastery, and lack of concern about adverse future consequences.

It is crucial to recognize that simply inducing the patient to act less depressed does not mean that he is less depressed. A tuberculosis patient can be medicated to stop coughing and can be fattened-up with forced feeding, so that he no longer looks emaciated. Yet the cavaties in his lungs remain just as large and caseous as ever. Similarly, a brain-damaged individual may be trained to perform certain motor movements without there being any backwards modification of his cerebral deficit.

THE MECHANICS OF COGNITIVE REORGANIZATION

George Kelly's notion of the patient and the therapist as scientists who are examining the patient's personal constructs is a useful metaphor for understanding the technique of cognitive modification. The patient takes his assumptions so much for granted that he usually is unlikely to articulate them until he is questioned about them. The therapist should help make the patient's assumptions explicit and then they should scrutinize, probe, and test them. This procedure may be carried out through questioning and by subjecting the construct (as opposed to the patient) to argument, in the Socratic sense: (1) eliciting the patient's reasons for believing in the assumptions, (2) marshalling up as a debate, the pros and cons of the particular construct. The notion, as in the Socratic dialogues, is to find the truth through verbalizing the opposite extreme positions on a given issue.

Another important approach to testing the patient's beliefs is through empirical demonstrations. It is possible for the two collaborators (therapist and patient) to set up an experimental situation in which the assumptions may be subjected to a test and an immediate answer can be obtained. We have carried out analogs of this procedure in particular tasks and also have used a clinical derivation of these experimental paradigms in such clinical treatments as the graded task assignment.

One line of inquiry into cognitive restructuring was based on the experimental manipulation of the patient's attitudes and the assessment of the effects upon other variables relevant to depression. According to our formulation, the depressed patient has unrealistically low concepts of his capabilities. If this negative orientation is alleviated then other symptoms of depression, such as sadness, hopelessness, and reduction of constructive motivation, should improve.

We found in a controlled study (Loeb, Beck, and Diggory, 1971), that depressed outpatients were significantly more pessimistic about their performance on a card-sorting test than a matched control group of nondepressed patients. Interestingly, the depressed patients performed as well on this task as the control group. On a second task in this manipulation, the previous experience of success or failure had different effects on the actual performance of the two groups: Success improved the performance of the depressed group, whereas failure improved the performance of the nondepressed group.

The study on depressed outpatients was repeated in a study of 15 depressed inpatients. In addition to specific measures of

self-confidence and expectancies regarding test performance, we included an assessment of hopelessness and a self-evaluation test. We found that following a successful experience the patients showed a generalized improvement in their self-esteem and optimism. Thus, the patients ~~showed~~ made more positive ratings about their personal attractiveness, ability to communicate, and social interests; they also saw the future as brighter and had higher expectations of achieving their major objectives in life. They also showed improvement in mood.

Another study of 15 depressed inpatients consisted of a hierarchy of tasks on a verbal dimension. The patients progressed in a graded fashion from a simple task -- reading a paragraph aloud -- up to the most difficult items on the hierarchy. The most difficult assignment, which all the patients were able to master, consisted of their improvising a short talk on a selected subject and trying to convince the experimenter of their point of view. Following this graded task assignment, we found significant improvements in global ratings of self-concept, optimism, and mood. (Beck, 1974, "The Development of Depression")

The finding that the depressed patient reacts positively to tangible evidence of successful or superior performance is most important and has important implications. The meaning of the experimental situation, in which the depressed patient receives immediate, concrete, positive, or negative information about his performance, obviously has a particular powerful effect. The tendency of the depressed patient to overgeneralize in a positive direction after "success" demonstrates that his negative cognitive set is malleable. The therapeutic application consists of devising

TARGET SYMPTOM	REASONS or MALADAPT. ATTITUDE	THER. APPROACH
1. Inactivity	Too Tired Pointless Will Feel Worse	Rational: 1. What lose by trying? 2. Has being passive done any good? 3. Will feel worse, if passive. Structured, Graded Activities "Success Therapy" "Graded Task Assignment"
2. Suicidal Wishes	No point to living Too Miserable → Escape Burden To Others "It will be endless" "Can Never Get What I Want"	1. Wish to Live - Wish to Die Scale. 2. Expose Ambivalence 3. Scrutinize & question "Reasons to Die" 4. "Alternative Therapy" a. Alternative ways to view problems. b. Alternative Actions
3. Hopelessness	Nothing will Work Out Right (similar to Suicidal "Reasons")	1. Empirical Demonstration of fallacy of Negative predictions. 2. Questioning "Reasons": How Can You Be So Sure?
4. Lack of Gratification	I can't enjoy Anything	1. Remove "Blinders" 2. Actually Look For sources of gratifications 3. Label them.
5. Self-Criticisms Self-Hate	Notion of Causality Primitive Judgment	1. ?Critical to another person. 2. Identify and reason with self-criticisms 3. Feel)sorry(for self.)empathy(
6. Painful Affect	MEANING: Things are rotten: Can't be changed.	1. Distract from monitoring affect. 2. Raise threshold by ignoring. 3. Counteract with contradictory affects: Humor, Anger. (Actually changes cognition set)
7. Selective Abstraction, Arbitrary Inference Overgeneralization		1. Question evidence for conclusions. 2. Expose faulty logic. 3. Alternative Explanations

techniques to pinpoint for the patient his specific cognitive distortions, and to demonstrate their invalidity. By achieving such a cognitive reorganization through behavioral or interview techniques, the patient may experience a rapid improvement in all the symptoms of his depression.

TARGETS OF COGNITIVE MODIFICATION

1. Target Symptoms: Inertia, avoidance, and resistance

It is obviously desirable to engage the depressed patient in more activity but of course, it is essential to create the motivation - the correct climate - for the activity. Also the activity must have some specific rationale.

There are many positive advantages from positively designed activities. Some of these benefits are:

a. Change in self-concept. (Patient can see himself as more masterful and less inept).

b. He can be distracted from his painful depressogenic thinking and his painful affect.

c. Environmental responses can be changed. That is, people will generally reinforce constructive activity.

d. There may be a change in the patient's affect.

The underlining meanings or connotations of inertia should be elicited by questioning:

a. "It is pointless to try."

b. "I can't do it."

c. "If I try anything, it won't work out and I'll only feel worse."

d. "I am too tired to do anything."

e. "It is much easier to just sit still. (following the line of least resistance)."

This kind of behavior in the past has been regarded as psychomotor retardation. However, numerous studies plus clinical experience shows that the patient becomes quite active when motivated either through desire to please or through the aversive consequences of being immobile.

It is essential to focus on these underlying meanings or connotations and to examine them with the patient. For instance, one of the connotations of being inert is that the patient is "lazy." He tends to hold this point of view as do the people around him. As a result, he criticizes himself -- as do the significant other.

The cognitive-behavioral approach consists of engaging the individual's interest or curiosity so that he will at least cooperate to the extent of providing answers or performing simple tasks. This can be accomplished through a novel presentation of a specific task; by explaining the rationale for the particular procedure; and by conveying to the patient that there is a less painful alternative to feeling as bad as he does -- namely, through cooperating with the therapist in involving himself in a specific activity. When the patient responds to the incentive to cooperate, then a variety of verbal cognitive or behavioral methods can be used.

In the case of inertia avoidance and resistance, the therapist can make statements such as the following to indicate to the patient how he is defeating himself and making himself more miserable by blandly accepting some of his self-defeating attitudes.

a. "You certainly are not getting anywhere by staying still. You have been doing this for a long time and you acknowledge that you are not feeling any better. What do you have to lose by experimenting with a different approach?"

b. Alternatively, an incentive to try a new program may be produced by the questions, "Do you feel that just lying around is going to make you feel any better?...Has lying around made you feel better up until now?...If it hasn't worked up until now, is there any reason why it should work now? At least if you try some other pattern, you stand a chance of improvement. It is conceivable, of course, that you might feel worse but one thing is certain, if you lie around the way you have, there is little chance at all of your feeling better."

c. "If you just lie around, you only castigate yourself and call yourself names such as lazy, inadequate, helpless...You have found that just lying around helps to keep you preoccupied with your self-critical thinking...You lay yourself open to being victimized by these painful thoughts and feelings.. You just don't give yourself a chance."

d. "How can you be so absolutely certain that you can't achieve this particular assignment unless you try?"

e. "Once you get going, you may find that it is easier to keep going than you realize. You will find you aren't too tired to keep at it..It might take a ton of coal to get a train started, but very little to keep it going."

f. Once the patient is willing to "take a chance,", behavioral tasks such as the Graded Task Assignment may be utilized.

2. Target Symptom: Hopelessness and Suicidal Wishes

When asked why he wants to commit suicide, the patient generally gives responses such as the following:

a. "There is no point to living. I have nothing to look forward to."

b. "I am feeling so miserable that this is the only way I can get out of it."

c. "I am a burden to my family and I can help them by removing myself."

d. "The future is black."

e. "I can't get what I want anyhow so what's the use in trying."

Note all of these attitudes obviously are related in some sense to hopelessness. If hopelessness is at the core of the suicidal wishes, a variety of methods can be used to convey to the patient that there are alternatives to his present way of looking at things and also to his present way of behaving. By examining his assumptions, the patient may be guided to shift the balance between life-preservative wishes versus self-destructive wishes.

Example: A teenage girl reported that her future looked pretty grim and she was seriously considering suicide. She stated as her reason for suicide that she had felt unhappy during most of her childhood and "the childhood is supposed to be the happiest period of your life." I was able to discuss with her that most people, I knew, were happier in their adulthood than in their childhood. The patient was surprised to hear this. After this single discussion, she revamped her thinking and several years later reported that she had not had any recurrence of her suicidal wishes.

The underlying assumptions of hopelessness and suicidal tendencies can be subtly undermined by skillful questions. By pointed, but friendly, questioning, the therapist can make the patient aware of the incongruity of some of his assumptions. The incongruity may help to shake up his belief system. As a minimum goal, the questioning should be directed to encourage the patient to see that the assumptions are ideas that can be examined rather than accepted as reality or unshakeable facts.

An example of showing the incongruities in a patient's belief system is presented in the following interchange with a patient who had made a suicidal attempt and still wanted to commit suicide "because her husband was unfaithful."

1. Question: Why do you want to end your life?

   Answer: Without Raymond, I am nothing...I can't be happy without Raymond...But I can't save our marriage.

2. Question: What has your marriage been like?

   Answer: It has been miserable from the very beginning... Raymond has always been unfaithful...I have hardly seen him in the past five years.

3. Question: You say that you can't be happy without Raymond... Have you found yourself happy when you are with Raymond?

   Answer: No, we fight all the time and I feel worse.

4. Question: You say you are nothing without Raymond. Before you met Raymond, did you feel you were nothing?

   Answer: No, I felt I was somebody.

5. Question: If you were somebody before you knew Raymond, why do you need him to be somebody now?

   Answer: (Puzzled) Hmmm...

6. Question: Did you have male friends before you knew Raymond?

   Answer: I was pretty popular then.

7. Question: Why do you think you will be unpopular without Raymond now?

   Answer: Because I will not be able to attract any other man.

8. Question: Have any men shown an interest in you since you have been married?

   Answer: A lot of men have made passes at me but I turn them away.

9. Question: If you were free of the marriage, do you think that men might be interested in you -- knowing that you were available?

   Answer: I guess that maybe they would be.

10. Question: Is it possible that you might find a man who would be more constant than Raymond?
Answer: I don't know ... I guess it's possible.

11. Question: You say that you can't stand the idea of losing the marriage. Do you think you really have a marriage or is it a marriage in name only?
Answer: I guess I really don't have a marriage.

12. Question: Then what have you actually lost if you break up the marriage?
Answer: I don't know.

13. Question: Is it possible that getting out of the marriage would offer you more opportunities?
Answer: There is no guarantee of that.

14. Question: What do you actually lose if you try?
Answer: (Long pause) Nothing, I guess.

Following the interview, the patient was more cheerful and it appeared that she was over the suicide crisis. She eventually was divorced and settled down to a more stable life.

3. Target Symptom: Self-Criticisms and Self-Hate

Cognitive Underpinnings: The depressed patient, as other people, seeks causality for his problems or the problems of the world. In his notion of causality, the depressed patient is prone to regard himself as the cause of all his problems. He may even carry this to seemingly absurd extremes: When it is pointed out that self-blame is maladaptive, he then blames himself for blaming himself. The self-criticisms take the form of "I am no good, I am a failure, etc." Of course, these ideas only make the patient feel worse. At times, he may feel hatred toward himself just as one would towards another person who acted the same way.

Among the cognitive techniques are the following:

a. It is important to give the individual objectivity towards his self-hate. One method is to ask the patient "Suppose I behaved the way you do (i.e. I made mistakes, etc.). Would you hate me for it?"

b. It is possible to turn off a negative self-evaluation. The following technique may be more applicable in moderately to mildly depressed patients. The therapist can say to them "How do you think I would perform if somebody was standing over my shoulder evaluating or criticizing everything I did?...In a sense, this is what you are doing without deliberately wanting to do so...The net effect, however, is that you not only feel bad, but you can't perform adequately. You will find that you can be as free with yourself and more successful if you try to ignore the self-evaluations."

4. Target Symptom: Painful Affect

The connotations of the painful affect seem to be that bad things are going to happen. This may be in line with Schachter's notions about cognitive labelling. It is conceivable that the individual has learned to associate sadness with the expectation of bad things happening. Therefore, the associative link remains: When he feels sad, he expects something bad to happen -- just as when a person feels anxious, he tends to feel that there is some danger.

In any event, because of the patient's negative expectancies, he tends to believe that his painful affect will continue on and on. The typical case of anxiety neurosis, in contrast, has less pessimism and, therefore, is not fixed on the notion that the anxiety is going to last forever.

Some of the cognitive behavioral methods are:

a. Distract the patient from examining and monitoring his sad feelings -- by engaging him in some potentially interesting activity. The selection of an activity cannot be arbitrary -- but should involve collaborative planning and often requires considerable ingenuity.

b. Emphasize to the patient that it is possible to raise his threshhold for pain by ignoring the unpleasant feelings. It can also be pointed out that the unpleasant feelings tend to build up to a peak and then diminish and that when it is peaking, he can predict to himself that it will probably diminish before long.

c. The painful affects can be counteracted often by inducing some kind of pleasurable affect such as humor. When a patient cries, he can sometimes feel sympathy for himself. His cognitive set changes from being hostile or derogatory to himself to that of being sympathetic with himself. Self-sympathy is probably inconsistent with the cognitive set of self-blame. In addition, as pointed out previously, expressions of anger can also induce a different kind of cognitive set.

Feeling sorry for oneself can be analogized with the kind of empathy one experiences with characters in a movie, who are wronged or unfortunate. The people in the audience get dewy eyes or sob because they <u>care</u> about the unfortunate character. Similarly, by feeling empathy for <u>themselves</u>, depressed patients are likely to be less self-critical.

This process can be accelerated by a number of techniques such as recounting a story of another unfortunate person with whom the patient can identify himself and feel sympathy for.